Email from Tom Rehak, 04/26/11

Metabolic Screening edits

As you know, the Metabolic Screening codes (H2010TD, H2010TE) were implemented in January 2010. Initially we indicated these procedure codes would be limited to pay on an annual basis. As these screenings occurred, it became apparent that some clients needed more frequent screenings. As you recall, we initially focused on changing the payment policy to limit payment to no more than one screening per 180 days, primarily to allow providers to align the screenings closer to the time of the client's comprehensive CPR evaluation. Subsequent discussion with the DMH NET internal group, and the presentation and discussion at the joint clinical manager/nurse liaison meeting in March, led us to conclude that screenings outside of 90 days would be clinically appropriate and medically necessary for some clients, and screenings inside of 90 days would not.

Accordingly, we will be limiting payment of these procedure codes to once every 90 days or more, and these edits are being built into both CIMOR and the MHN MMIS system. Please note, as usual, this is a payment edit to prevent inappropriate and/or inadvertently incorrect billing, it is not a standard of care for every client. Most CPR clients will need just one screening annually, which is the minimum requirement, while a smaller group may require more frequent screenings, as medically necessary. We will be applying these parameters to all metabolic screening claims paid thus far, and, of course, to future claims. We have initially identified approximately 100 clients who received more than one metabolic screening paid by DMH/MHN in calendar year 2010, and about half of those indicate screenings that were paid less than 90 days apart. This claim information will be sent to providers under separate cover, and the payments must be adjusted (returned) to the state. We will run subsequent reports to identify any additional paid claims outside of these parameters and require adjustments on those.